ADULT CARE HOME ADMINISTRATOR PRACTICE GUIDELINE

This guideline was developed as a cooperative effort between the Kansas Department of Health and Environment and representatives from the Kansas Professional Nursing Home Administrator Association, the Kansas Health Care Association and the Kansas Association of Homes and Services for the Aging.

Definition of practice area: For the purposes of this Guideline, elopement of a resident is defined as the leaving of a facility without the knowledge of staff of a resident who has impaired decision making ability, is oblivious to own safety needs and those at risk for injury outside the confines of the facility.

Scope of the problem: In the fourth quarter of 1996, 2,213 residents were identified at Section E 3 of the Minimum Data Set Plus as exhibiting "wandering with no identified purpose; resident appears oblivious to needs or safety." Thirty-four elopements were reported by adult care homes during the fourth quarter of 1996. One reported elopement resulted in the death of a resident.

ADMINISTRATIVE PROTOCOLS

The adult care home administrator is responsible for ensuring that effective policies and procedures are developed and consistently implemented to reduce the risk of elopement by residents. The following are recommended components of an effective elopement policy.

A. Each facility should define what would constitute risk for injury of a resident based on the physical environment in which the facility is located. In some facilities, residents are at high risk for injury just leaving the facility building. In other facilities, the risk for injury would be minimal if the resident remained in the immediate area of the building. In rural communities, a resident may be able to safely walk to familiar places within the community. Consideration should be given to vehicular traffic in parking lots and adjacent streets or highways, the presence of railroads, streams, ponds, rivers, drainage ditches, etc. near the facility as well as other environmental factors. The facility has the responsibility to maintain a system which protects residents who are not capable of protecting themselves.

B. Prior to or at admission, each resident should be assessed for the potential for elopement.

    1. Does the resident have a prior history of wandering reported by family or other caregivers?

    2. Does the resident's history or assessment indicate impaired decision making and/or impaired cognition and the ability to be mobile by walking or use of wheelchair or similar device?

    3. Specific interventions should be developed and implemented on the day of

admission for residents with a known history of wandering.

4. Residents who develop wandering behavior after admission to the facility should be reassessed and appropriate interventions included in the plan of care within seven days of identification of behaviors which include wandering.

5. Facility policy should support a process that residents who are identified as being at risk for elopement are accounted for every 30 minutes.

6. Residents without a history of wandering and/or elopement should be accounted for at least every two hours day and night.

7. The facility should identify key shifts or periods during the day when elopements appear to be most frequent. In some facilities it maybe during the night shift and in others, it maybe the period after supper when visitors are leaving. More intensive protocols need to be developed and implemented during the high risk time periods.

8. The facility should have a system of identification of residents who wander. The method should be designed to assist law enforcement and others in identifying a resident who has left the facility without staff knowledge.

    1. Identification bracelets on a wrist or ankle.
    2. Identification on or in the resident's clothing.
    3. Photographs of resident taken at admission. Photographs may need to be retaken as the resident's physical appearance changes.

9. At admission, all residents should be informed in writing of the facility's method for accounting for residents who leave the building. One method frequently used is to ask residents to sign out when leaving the building and/or grounds.

C. A specific system should be developed to notify staff that a door has been opened in an area accessible to residents.

1. Door alarms are tested each shift at least once a month. The results of the tests are recorded. Testing of the system should include not only that the alarms function, but also that staff respond appropriately to the alarms.

2. A specific policy and procedure developed related to the disabling of door alarms. Who can make this decision? When is it permissible for door alarms

to be turned off? Who is responsible for resetting the system?

3. When an exit door which remains unlocked during the daytime cannot be monitored from the nurse's station, auxiliary monitoring systems must be in place such as video cameras, mirrors or individual resident safety alarm systems.

4. A specific procedure developed for implementation when the exit door alarm system or individual resident safety alarm system is known not to be functioning.

D. Staff who do not follow the facility's policies and procedures for prevention of elopement must be counseled, educated and disciplined to protect the health and safety of residents.

E. Policies and procedures are developed and implemented to find a resident whose whereabouts cannot be accounted for by staff.

1. A system developed to inform the administrator or designee and all departments immediately that a resident cannot be found.

2. A search of the facility building and grounds is conducted promptly. Who is responsible for performing this task?

3. Staff on duty should determine, if possible, the time and location the resident was last seen.

4. A system to notify law enforcement of an elopement. Who has the authority? What law enforcement agency is to be notified? How soon after a resident is not accounted for must law enforcement be contacted?

5. Who is responsible for notifying the resident's legal representative or family? When is that notification to occur?

6. Who is responsible for determining whether the elopement occurred as a result of neglect and reporting the incident to KDHE?

F. A specific protocol should be developed to prevent elopement by residents identified at risk for elopement. All staff members should be aware of the protocol.

1. The facility protocol for prevention of elopement is included in the orientation of all employees.

2. At least once a year, the facility conducts an inservice concerning elopement and implements the facility procedure.

NOTE: There will be instances when in spite of an effective system in place, residents will elope. The issue for the survey agency is whether or not the facility has acted in a prudent manner to prevent the actual or potential elopement by a resident. Surveyors will use this document as a guide for decision making.